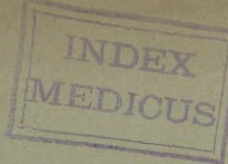


KELSEY
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(Chas. B.)

HOW TO OPERATE
FOR
HEMORRHOIDS.

*A Clinical Lecture on Diseases of the Rectum, delivered
at the New York Post-Graduate Hospital.*

BY
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REPRINTED FROM THE THERAPEUTIC GAZETTE, APRIL 15, 1893.

DETROIT, MICH. :
GEORGE S. DAVIS, PUBLISHER.
1893.



How to Operate for Hemorrhoids.

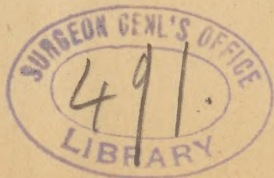
GENTLEMEN:—I want to show you to-day something of a curiosity. It is simply the largest mass of hemorrhoids I have ever seen or operated upon.

The patient, as you see, is an old man—nearly seventy—and he is a physician. Few men, except physicians, would ever go as long without treatment as he has done, for he has suffered many years. He tells me, also, that his father and his brothers have all suffered in the same way, and that his brother had three operations at intervals.

Well, we shall not operate three times on this man, in spite of his doubts as to whether a single operation will effect a radical cure.

He has asked me whether there is anything hereditary in piles. I do not know. That many members of the same family may be similarly affected is certain. It has been my own experience to operate upon three generations of the same family; but, beyond the almost universal prevalence of the disease, I have never been able to decide upon any hereditary influence.

And now, as I stretch the sphincters, you see two immense tumors roll out of the anus, one



on either side, and so well developed are they that they have become quite distinct from the coats of the rectum proper and are only attached to it by pedicles of mucous membrane and blood-vessels. They have grown larger and larger as time has progressed; they have become more and more like foreign bodies every year; the act of defecation and extension has pulled them away and separated them from their first position, until now they are quite pendulous and pedunculated, and the pedicle, though broad, is very thin and composed of blood-vessels and a little connective tissue, covered over by the normal mucous membrane. The tumors on each side are, as you see, fully as large as large hen's eggs.

A gentleman asked the other day, after seeing the clamp and cautery operation on a case of rather small tumors, what operation we did for the large ones, his idea being that the clamp, though it might be safe enough for small or even moderately large tumors, would not do for cases of any magnitude. This is a good time to answer his question. I have never operated by any method on tumors of this size, but I propose to now upon these with the clamp and cautery, and I am willing, in the presence of you all, to make this a test case. If the cautery fails to control the bleeding, if the man has any accident from hemorrhage, I will in the future practise the operation by the ligature in preference to that by the cautery.

The test is not a fair one. Accidents have occurred by the ligature, and only a short time ago a man nearly bled to death in one of our hospitals after Whitehead's operation; but if this man bleeds we will admit that it was due

to a fault of the operation, and will seek a better one.

You perceive that the pedicles here on either side of the rectum are too large to be included in my clamp, even though it is rather longer in the blades than those usually sold. The first step, then, will be to divide one of these tumors into two equal portions with the scissors. I cut boldly into it parallel with the axis of the gut, then take one-half, make a deep groove on the cutaneous aspect of the pedicle with the scissors to hold the clamp, apply the clamp in the groove firmly, amputate the tumor we are dealing with, and thoroughly cauterize the stump. The same is done with the other section, and you see the result,—a stump the length and size of the index-finger on one side of the anus, which has a firm eschar covering it, and which is perfectly dry. The opposite tumor, about the same size as the first, is treated in the same way: first divided into two portions from apex to pedicle, then each portion separately clamped and cauterized.

Now, you may ask, why do I not tie these pedicles instead of cauterizing them, and I will answer plainly that it is simply to prove to you that in this very unusually severe case the cautery will control the bleeding as safely and as efficiently as the ligature.

The great fear in the minds of the profession regarding this method of operation is the fear of hemorrhage; it is the fear that was in the mind of the student when he asked what operation we did on the big cases. And I simply want to prove to you that no matter how severe the case, the clamp is as safe as the ligature. This I have always held and still hold. It is

the basis of the whole question. Given a single exception, a single case in which the cautery, thoroughly applied, fails to control the bleeding from the stump of an amputated pile, no matter what its size, and the operation falls to the ground.

But my contention has always been that if the cautery were as safe as the ligature in this one particular, then it was for other reasons a better operation than that by the ligature, with which it must be compared ; better in this, that there is no ligature surrounding a mass of tissue left in the gut, no string tied tightly around a nerve as well as the blood-vessels, and often causing intense pain till it sloughs away. In consequence of this we have less pain, less vesical disturbance, and a more speedy recovery.

Do not understand that I am an opponent of the operation by ligature, for, unless I believed the clamp and cautery a little better, I should always practise it. It is safe and sure and speedy. The patients have some pain, some of them a good deal, but they are radically cured without accident. Allingham says the cautery is at least six times as fatal as the ligature. By the same reasoning it would not be hard to prove that the ligature was at least twelve times as fatal as the clamp. Nothing will lie like figures,—except facts. Allingham can undoubtedly find a thousand cases of the clamp operation in which the mortality shall be six, and oppose them to a thousand cases of the ligature in which the mortality is zero, and with very little trouble I can reverse the figures. The truth seems to me so manifest that I lose patience with this

form of argument. Accidents and death may and will follow any operation which is thrown out to the profession at large to be practised. I know one practitioner whose death-rate with the clamp is one hundred per cent., he never having operated but once, and lost his case from primary hemorrhage. I know of deaths from the ligature. I know of bad results from Whitehead's operation. But the operation by the ligature, when properly done, is as safe as any operation can be, and that with the clamp is as safe in correspondingly good hands as that with the ligature.

We all have our favorite methods of doing things. Personally I claim only for the cautery that my patients get well a little quicker and with less trouble and suffering than they do with the ligature, but the moment I am convinced that it is any less safe than the ligature I will abandon it. I attack no other operation. I do not claim any additional safety for the clamp; but, as far as my knowledge of it goes, I am ready to defend it from any attacks on the score of additional risk.

Let us go still further into this question. Here we have two operations equally safe, equally radical, each as satisfactory as any surgical procedure can well be, and by one or the other, as you may prefer, every case of piles may be cured with little suffering or inconvenience to the patient. Have we any others? None, I am sorry to say, as good as these, to my own mind, and yet there are many that may be practised. Take, for example, the operation described by Whitehead, which consists in dissecting off the mucous membrane and submucous connective tissue (the latter at

least in part) from the anus upward for about an inch and a half, amputating it by a circular incision, drawing down the stump and suturing it to the margin of the skin. By thus dissecting up and cutting off a cylinder of mucous membrane and hemorrhoids, the whole "pile-bearing area" is removed, and a recurrence is thought to be impossible. Much stress is laid upon this impossibility of recurrence, as though the operation were in this respect more radical than those already mentioned ; but such I do not think to be the case. Scarcely any operation can be devised less likely to be followed by a recurrence than that of the clamp or the ligature, and the experience of all surgeons will bear out this statement. I have personally never operated twice on the same patient for hemorrhoids, except in two cases, and Allingham, with a still longer experience, says the number of cases in which he has been called upon to operate the second time can be counted on his fingers. One of my cases you saw here, and under ether it was seen that there was no tumor, but merely a vascular area, which sometimes bled after the straining of defecation. Indeed, this charge that the time-honored radical operations for piles which have been relied upon with perfect confidence by surgeons for years were not radical, struck me, at the time Whitehead's operation first came into vogue, as amusing, and I have never been at all inclined to admit that a new procedure was at all in demand for any such reason, though, if it had any other recommendation, I was perfectly willing to adopt it as a substitute. I have never found that it had, and have never, therefore, practised it, though many others

have done so and with good results. In this matter I agree with the late Henry B. Sands, who said that the ligature had answered him so well all his life that he had no idea of abandoning it for anything else.

And yet there are objections to Whitehead's operation by excision, as there are to most surgical operations. The objections to this are chiefly two.

When the circular incision, which should be made at the junction of the skin and mucous membrane, is made a little too far outside, a very serious eversion of the mucous membrane is the consequence. The skin, when loosened by the incision, easily retracts. The stump of mucous membrane, when united to it after the amputation, readily slides down and out of the anus, and when firm union between the two has taken place, the natural muco-cutaneous orifice of the bowel is changed into one covered entirely by mucous membrane, which soon becomes raw and ulcerated by exposure. There have been several of these cases in New York. Personally I have been consulted in three, and I have known of others; and all that I have seen or heard of have resulted from operations in different New York hospitals, except one. I add this because it might be thought that such a result could only result from ignorance or carelessness. It may be a fault of the operator and not of the operation, but it seems a fault to which very good operators are liable.

Exactly how to treat such a condition it may be difficult to say. My own idea would be to destroy the everted and adherent mucous membrane (for it is not a prolapse in the ordinary acceptance of that word, but a substitution of

mucous membrane for skin) and allow a cicatrix to take its place, trusting to dilatation to prevent stricture of the anus. However, I have never been able to convince one of these patients that they had not had all of the operations for piles they cared to submit to.

The other objection comes from failure to get union by first intention between the skin and the stump of mucous membrane. When the stitches tear out, the membrane slides back into the rectum, and a circular granulating wound more than an inch in breadth results. When this has cicatrized, a very pretty stricture of the anus is the natural consequence. This also I have seen where it was not to be attributed to any fault of the operator.

There are many other ways of removing hemorrhoids besides these three. Crushing is one, but to my mind so poor a one that I have never used it. There are also various methods of excising the tumors and suturing the mucous membrane after the tumors have been cut off, so as to get immediate union. In fact, it requires no great ingenuity to invent some new technique in accomplishing their removal; but as all the operations lead to the same end, and all of them are more elaborate and require more time than either the clamp or the ligature, and have no advantage over them in certainty of result or avoidance of suffering, you see me here still keep to the operation I much prefer. Allingham gives about one minute to the ligature of an ordinary case of piles after he gets to work; the clamp is fully as speedy; both can be done while the patient is in the primary stage of anæsthesia; both are as satisfactory as any operation in surgery. For these

reasons I have never given much time or thought to the various more or less elaborate methods of accomplishing the same end as they appear from time to time in the journals.

So much for the radical cure of hemorrhoids. But the average man only wants his hemorrhoids cured when he is suffering pain,—that is, if they are to be cured by an operation. And as the pain of the disease is very intermittent, and, as a general rule, he suffers only a certain amount of annoyance and discomfort from them, it follows that he will seek relief in many ways, and if he does not find it, will carry his piles with him through a long life down to the grave. It is, therefore, a very desirable thing to be able to do something for these patients that shall satisfy them,—something that will stop the bleeding and protrusion and yet shall not be “an operation” that will compel them to be laid up. The knife they fear, ether carries with it a great dread, and the ligature is not pleasant to contemplate.

Can we meet this legitimate want on the part of the public? In a measure, yes. We can by several means arrest bleeding. By more serious measures we can reduce the size of the tumors till they shall no longer protrude at stool. The relief will probably not be permanent; the pain may be considerable; it is, in fact, the old story of cutting off the dog's tail by inches to avoid hurting him; but if the patient prefers that kind of surgery, after it has been explained to him, there are ways of doing it without any special danger, and the practitioner is justified in using them. It is true that only enough of the caudal appendage will

probably be removed to make a very unsatisfactory stump in the eyes of the surgeon, but if the patient wishes it done, I hold that, as long as no false promises are made, it is a justifiable concession to his fears and desires.

The best known, but I think not the most desirable, method of accomplishing this is by the injection of carbolic acid into the tumors. With a fine and clean hypodermic syringe inject from 5 to 10 drops of a ten-per-cent. solution of carbolic acid, in a menstruum of equal parts of glycerin and water, into the centre of each hemorrhoid. When it works nicely there will be a little smarting only at the time and soreness for a few days after, and the foreign substance will set up just sufficient irritation to cause some consolidation around it, and hence decrease in the vascular supply, with decrease in size and in the amount of bleeding. After all of the piles have been injected,—some once, others several times,—the patient will consider himself cured. The tumors will no longer bleed or protrude at stool, and he is very grateful. The relief will probably last three or four years in a favorable case, and then he will return, and you will find a decided change. The tumors now are harder and firmer to the touch, and the skin of the margin of the anus is more involved in them. They are, in fact, covered by muco-cutaneous tissue instead of velvety mucous membrane, and they are much less amenable to a second course of the same treatment than they were to the first.

This is the course of a favorable case, but all cases do not act in this way by any means. The variations from it are manifold.

Some day you will make the usual injection,

as you have done dozens of times before, and your patient will suffer great shock. Exactly why it is hard to tell, but he will either faint on the table or will get cold ; his pulse will become weak ; you will think he is about to faint,—as, indeed, he is,—and you will rush for stimulants. After an hour or so he will probably be able to leave the office and go about his business, but it will be many days before you will cease to wonder what was the matter with him. Finally, you will call it nervous shock, but you will not be anxious to inject him again. On that score, if your experience is like mine, you need not have any uneasiness. He will not come back. You have lost your patient.

In another case, after the injection, your patient goes out of the office with only the usual smarting and pain ; but, instead of subsiding, it goes on increasing, and after a few hours you will get an urgent request to come to him at once. In fact, you may get a telegram, as I once did, saying that the patient is suffering the “torments of the damned.” You go with a hypodermic syringe in your pocket, and as soon as you arrive you use it,—this time for morphine, however. After awhile the pain is overcome, but again you don’t know what has happened. The man is all right after a day or two, but he never has another injection, and again you have lost your patient.

In another case the history will be as follows : After the usual glowing prognosis of no pain, no interference with business, etc., you make an injection, and tell your patient to come again in a few days. At the end of a week he appears. Perhaps he has been in the house since the last visit, and perhaps he has

dragged around at his business, but he has certainly had a good deal of pain. On examination you find quite a deep slough, the size of a silver quarter, covering the point of injection. That particular hemorrhoid, you may be sure, is in a fair way to be cured, and you inject another one. The same result follows, and after four or five weeks of pain and partial disability, if the sloughs heal kindly, the patient is discharged from treatment. He has had rather a hard time,—much harder than either of the radical operations would have caused him; but still he will not again be troubled for some years, and if he is satisfied, perhaps you may be. I have noticed, also, that after three or four years, when these patients come around again to talk about having something done for their piles, they do not take kindly to the idea of a second course of treatment by injections.

Exactly why sloughing will result in one patient with weak solutions, and will not in another, though much stronger solutions are used, it is not easy to say. Such, however, is the clinical fact.

Another class of cases will give you still more trouble. After the first injection, or perhaps not until after the second or third, the patient will go to bed and send for you on account of his pain. You find on examination a painful tumor at the verge of the anus, the size of the end of the thumb, covered partly by skin and partly by tense mucous membrane. This is a marginal abscess. It means much pain and confinement to bed for several days. Then it bursts, generally on the skin, and again on the mucous surface, and a short fistulous track half an inch or

an inch in length is left between the two openings. This may heal spontaneously, or may have to be cut. In any event, the patient has carried the treatment as far as he will, and you will get no credit.

In another class of cases you will be surprised at the powerful effect of your remedy, and you will get a partial cure from a single injection, but not much to your gratification.

On the day after the injection the patient will send for you, and you will find not only the pile you injected, but all his piles, inflamed, prolapsed, and strangulated. You will be surprised to find how much more hemorrhoidal disease he has than you supposed when you made your injection. You keep the man in bed, apply poultices and anodynes, give a cathartic to act on the portal circulation, and leave the case to nature. Part of the protrusion will slough off, and when the inflammation has subsided and the protruded mass returned, the patient will be partially cured.

But these are not all the complications. There is a peculiar blind, internal, submucous fistula which often owes its origin to an injection of carbolic acid. The piles may be cured as far as the patient knows, but instead of being well, he has a new symptom,—a sense of discomfort, often of actual pain, in the rectum, back, legs, and urinary organs. He goes from doctor to doctor, and nothing is found, till finally some diagnostician more thorough than the others finds a drop of pus coming out of the mucous membrane, just above the internal sphincter, and a small probe passed into the point from which the pus exudes will follow a submucous fistulous track for an inch or more.

The injection did not cause a slough over its point of deposit and allow of the escape of matter in that way, but the pus, when formed, followed the course of the needle and escaped at the point of puncture. The same patient may have two, three, or even more of these fistulæ,—one, in fact, for each injection.

These are the minor accidents and complications of this method of treatment. There are graver ones,—large abscesses, deep and extensive perirectal inflammations resulting in bad fistulæ or dangerous illness, and ending in permanent disability or death. More fatal results have been reported in this country from carbolic-acid injections in the last ten years than from all of the radical operations combined. A fatal result I have never seen, but all of the other accidents have happened to me personally, and combined they constitute a perfectly satisfactory reason for your not seeing me use the treatment here. Almost every week you see me operate with the clamp and cautery, and during the three years of this clinic you have never seen a failure to cure and never any complications such as have been described. Therefore I say to you, if you want to cure your patients and sleep comfortably yourself, use one of the radical operations. If you want to try palliative treatment, go very gently. Carbolic acid is only a palliative at best.

Besides carbolic-acid injections, there are several other means of relieving the worst symptoms of hemorrhoids. What is most often complained of is perhaps bleeding, and this can often be controlled for a time with applications of fuming nitric acid. The piles are

extruded, wiped free from mucus with a pledget of cotton, and touched freely on the mucous surface with nitric acid on the end of a match. If the acid is kept on the mucous surface there will not be very much pain at the time, though there will be soreness afterwards. Of course a superficial slough is formed, and when this has separated, and cicatricial tissue has taken its place, there will be some decrease in size and a cessation of the bleeding. The relief, however, is but temporary.

One form of hemorrhoid (the *nævus*-like growth which is flat and very vascular) can be cured by a thorough application of nitric acid. This is the form that bleeds so profusely, and yet does not consist of a tumor with increase of connective tissue, but merely of a circumscribed spot of greatly increased vascularity. In larger tumors, however, only palliation is to be expected. Unless very deep and unjustifiable sloughs are produced, there will be no great diminution in size, and hence no marked amelioration in the protrusion.

Instead of nitric acid the galvano-cautery may be used for the same purpose, and cocaine may also be employed if the patient is very sensitive. As long as the cautery is applied superficially, no great harm will result and temporary good may be done. If the cautery be plunged into the substance of the tumor a number of times, you can effect a cure lasting a number of years, but again you run many of the risks of an injection of carbolic acid,—that is, you are likely to cause suppuration in the tumor and marginal abscess. The danger of diffuse inflammation does not seem to me so great with galvano-puncture as with carbolic-

acid injections. In the one case your irritant can be more definitely limited in its effect than in the other.

These, in addition to the ordinary rules for medical treatment, regulation of the bowels and the action of the liver, avoidance of excess, especially in alcohol, etc., constitute practically our only resources in the palliative treatment of hemorrhoids. You will soon learn that the moment you grow ambitious to cure by these palliative surgical measures, the measures will be found very ill adapted to the purpose. My advice to you would be to use your palliatives gently and not to promise much from them; and when you find a patient willing to be radically cured, employ either the clamp or the ligature. In this way you will avoid failure on the one hand and accident on the other. Above all, make your patient understand what you are going to try to do beforehand.

JANUARY 16, 1893.

WHOLE SERIES, VOL. XVII.

No. 1.

THIRD SERIES, VOL. IX.

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Subscriptions and communications relating to the business management should be addressed to the Publisher,

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714 Filbert Street, Philadelphia, Pa.

Published on the Fifteenth Day of Every Month.

SUBSCRIPTION PRICE, TWO DOLLARS A YEAR.

Agent for Great Britain: Mr. H. K. LEWIS, Medical Publisher and Bookseller, 156 Cover Street, London, W. C.

Entered at the Post-Office at Philadelphia, Pa., as second class mail matter.

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